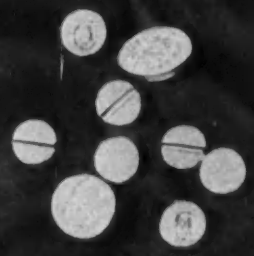
MEDICAL WORLD NEWS

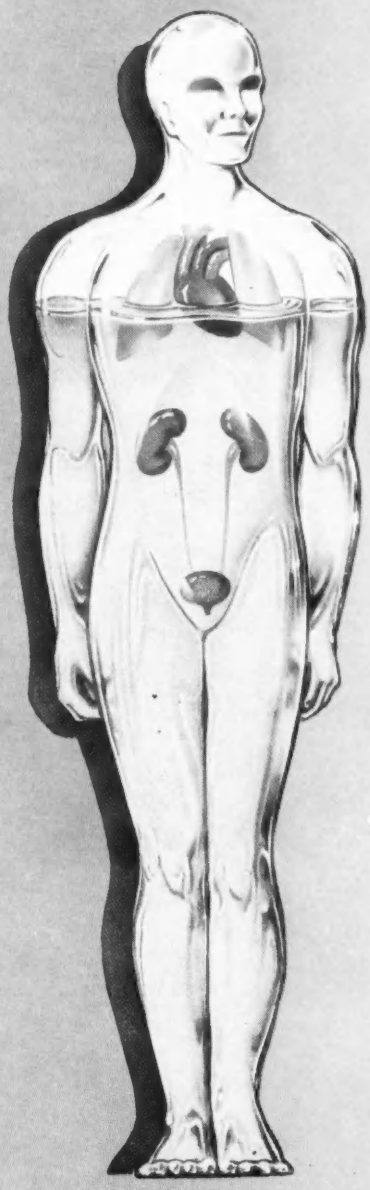
MARCH 17, 1961

$50 MILLION RACKET IN COUNTERFEIT DRUGS



Effect of Chemotherapy On Secondary Cancers

DOs and MDs Explore Scientific Differences



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hypertension

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Reaches all nasal and paranasal membranes, huh?"

...and for humans with RUNNING NOSES...

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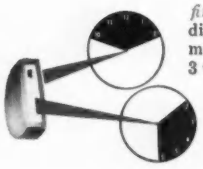

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then—the core disintegrates to give 3 to 4 *more* hours of relief

Each Triaminic timed-release Tablet provides:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides:

½ the formulation of the Triaminic Tablet.

Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides:

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Dosage (to be administered every 3 or 4 hours):
Adults—1 or 2 tsp.; *Children 6 to 12*—1 tsp.;
Children 1 to 6—½ tsp.; *Children under 1*—¼ tsp.

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VOL. 2, NO. 6

MEDICAL WORLD NEWS

THE NEWSMAGAZINE OF MEDICINE

MARCH 17, 1961

CONTENTS

On the cover: Prescription drug counterfeiting, an estimated $50 million business in 1960, is on the increase, according to Government and industry leaders. Story on p. 22

Departments

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LATE

PROSTATECTOMY QUESTIONED IN SMALL CANCERS

Total prostatectomy is rarely indicated for cancers that are small, confined and asymptomatic, says a Portland, Ore., physician. Furthermore, the procedure is "being improperly promoted."

Speaking at the Western Section of the American Urological Association, Dr. Thomas R. Montgomery said a 50/50 chance of complete cure is the best odds the operation offers, then only at the sacrifice of sexual function and possibly of urinary continence. This rarely appeals to patients "as a deal they care to accept."

Nor should they, Dr. Montgomery concludes after a 12 year study of 35 patients treated more conservatively. Thirteen had transurethral resections, 14 retropubic enucleations, eight perianal enucleations. Thirteen were given estrogens following surgery and seven were castrated. Ages ranged from 50 to 92 years, an average of 72.2.

During the 12 years, not one patient died of prostate cancer. Cardiovascular diseases killed 20, pneumonia one, renal failure one, cancer of the lung one. Another patient committed suicide. Eleven are still alive.

Concludes Dr. Montgomery: "It is obvious that one is not guilty of bad practice or incompetent urological care by treating these patients conservatively."

ALCOHOL REGIMEN ENDORSED FOR FAT-EMBOLISM PATIENTS

For prophylaxis against fat embolism following fractures, give your patient a shot of whiskey, says Dr. Leonard F. Peltier of the University of Kansas.

The serious results of fat embolism, Dr. Peltier believes, do not stem primarily from mechanical blockage of the pulmonary vascular bed, but from the subsequent hydrolysis of the emboli. This can be measured by serum lipase elevations.

To test this hypothesis, he and an associate, Dr. Federico Adler, studied a series of 52 patients with intertrochanteric fractures of the femur. Half the patients were dosed with quinine sulfate or ethyl alcohol, both of which inhibit fat hydrolysis; the other 26 served as controls.

More than half the control group

showed elevated serum lipase; three died of fat embolism. Of the ten quinine treated cases, lipase rose in 40 per cent, with one embolism death. Alcohol, used in 16 cases, held lipase to normal levels in three-quarters of the patients; none died of embolism.

Dr. Peltier prescribes 30 cc of 50 per cent ethyl alcohol (translation: "a shot of 100-proof bourbon") every three to four hours. Where oral intake is contraindicated, he substitutes 2,000 cc per day of five per cent alcohol in five per cent glucose (equivalent to two quarts of beer).

HUMAN WART VIRUS RESEMBLES ANIMAL POLYOMA VIRUS

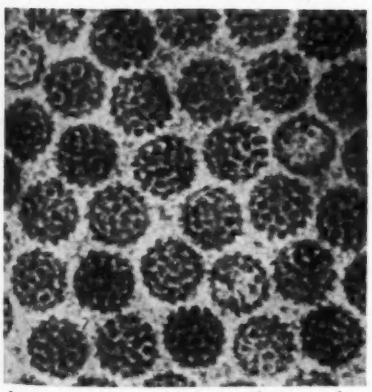
Toronto electron microscopists have taken a close look at the human wart virus and come up with a surprising picture.

Using negative staining and shadowcasting techniques to bring out the fine structure of this relatively small virus, Dr. A. F. Howatson and dermatologist Murray Williams found large quantities of virus particles which were composed of symmetrically arranged subunits similar to those of other viruses.

But they also found that the surface of the particles contained 42 subunits or capsomeres, which they believe may be a protein or perhaps desoxyribonucleic acid (DNA).

These occur in the same number and precise arrangement as that found in the polyoma virus.

"It is of interest," the Ontario Cancer Institute team comments, "that



the wart virus which produces a benign tumor in man is structurally similar to the polyoma virus which produces a wide spectrum of malignant tumors in several species of animals."

GERMAN CHOLEDOCHOSCOPE PUTS BILE DUCT ON DISPLAY

Until recently, the common bile duct has defied direct observation.

A small bent tube with a built-in light, an irrigating device and a complicated lens system which opens the common duct to view has been devised by a German surgeon, and has been brought to the U.S. by Dr. Clarence J. Schein of New York's Montefiore Hospital.

The last three inches of the choledochoscope, Dr. Schein points out, are angled at 60 degrees. As this angled part is moved into the duct, a saline solution flows through it, cleaning the duct and causing it to expand enough for further passage. A tiny lamp and miniature lenses send back a clear picture to the physician.

The choledochoscope "has already greatly increased our knowledge of the pathology of the bile duct, and has made possible the certain removal of obstructions and the detection of tumors in a place which up to now has been beyond inspection," Dr. Schein comments.

DR. SCHEIN's instrument "sees" duct.

SNAKES SERVE AS WINTER HOST FOR ENCEPHALITIS VIRUS

Only a virus would spend the winter with a snake. And that, apparently, is just what the western equine encephalitis virus does, according to Drs. Leo A. Thomas and Carl M. Eklund of the National Institute of Allergy and Infectious Diseases' Rocky Mountain Laboratory.

In the summer, birds infected by the Culex tarsalis mosquito (primary vector of WEE virus) serve as a reservoir of infection. But until now no one had discovered how the virus maintains itself in winter.

The Rocky Mountain investigators got their clue when they spotted the C. tarsalis mosquito swarming over a colony of hibernating garter snakes.

Tests later proved that the reptile is not only susceptible to infection but that the resulting viremia is of high titer and long duration. Wild snakes inoculated with the virus in the fall, then allowed to hibernate, reappeared in the spring still carrying the virus in high titers.

Moreover, they report in *Proceedings of the Society for Experimental Biology and Medicine*, uninfected C. tarsalis mosquitos allowed to feed on the inoculated snakes could infect one-day old chicks after nine to 23 days. And the virus could be recovered from both insect and chick.

With the coming of spring, the investigators expect to complete their case by examining the remaining question: Will wild garter snakes collected in fields also carry the virus?

HORMONE FOUND IN HOGS RELEASES STORED FATS

A new hormone that may have something to do with atherosclerosis and obesity has been found in the pituitary of hogs. When injected into rabbits or guinea pigs it releases stored fat into the blood.

The yet unnamed hormone, tagged only as "Fraction L" by Dr. Daniel Rudman of the Columbia University Research Center in New York's Goldwater Memorial Hospital, is the tenth pituitary hormone to be found.

While several other hormones play a part in releasing fat into the blood —as adrenalin, insulin and ACTH— Fraction L seems to have no other biological effect but fat mobilization, says Dr. Rudman. It appears to be highly species-specific also, being effective on guinea pigs and rabbits, but not on rats or mice. It is not known whether the hog-extracted hormone would be active if injected into man, nor has it been tried on hogs since Dr. Rudman receives glands from slaughterhouses.

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1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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A LETTER FROM THE PUBLISHER

JMA's DR. TAKEMI

Japanese physician Dr. Taro Takemi is faced with a sight familiar to the American practitioner—a large stack of unread journals. This picture of the president of the Japanese Medical Association reminded me that the "log jam" in medical communication is not exclusively an American dilemma. It also reminded me that it was just about a year ago that we began to put together the first issue of MEDICAL WORLD NEWS, a publication purposefully prepared to help break the medical communications bottleneck.

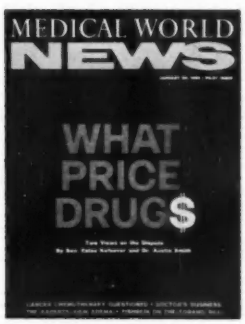
Our editor, Dr. Morris Fishbein, executive editor Bill White, and I had been talking for a long time about what we were going to say in our new publication and how we were going to say it. At first we thought of publishing MEDICAL WORLD NEWS as a tabloid newspaper, and only after long deliberation and much discussion came to the conclusion that the newsmagazine format would best serve the needs of the profession.

But having agreed on this, we soon discovered that each of us had radically different ideas about such basic things as column width, type face, letter-spacing, picture-cropping, cover-styling and the other mechanics of magazine-making.

As you might suspect, we didn't come up with just one dummy, but rather a dozen, each with its own merits and weaknesses. The job of settling on a style which combined cohesion and dynamics took weeks of typesetting, proof-pasting, picture-picking, color-choosing. Finally, after much friendly bickering and countless changes, we came up with our pilot issue. Several weeks later, when the first issue for physicians went to press, we felt we had made a good beginning toward our goal.

We've changed the magazine quite a bit in the past year—for the better, we hope you'll agree. We intend to change it lots more in the years to come, as new ideas and new developments give us the opportunity to provide you with a continuously valuable magazine.

Perhaps something of this was apparent to the Japanese doctors who crowded around one of our Tokyo writers, Bill O'Neill, the only foreign correspondent to cover the physicians' protest rally in Tokyo's Hibiya Hall. Interviewer O'Neill, whose story begins on page 17, found himself giving out as much information as he took in, because so many Japanese doctors wanted the subscription data on MEDICAL WORLD NEWS.

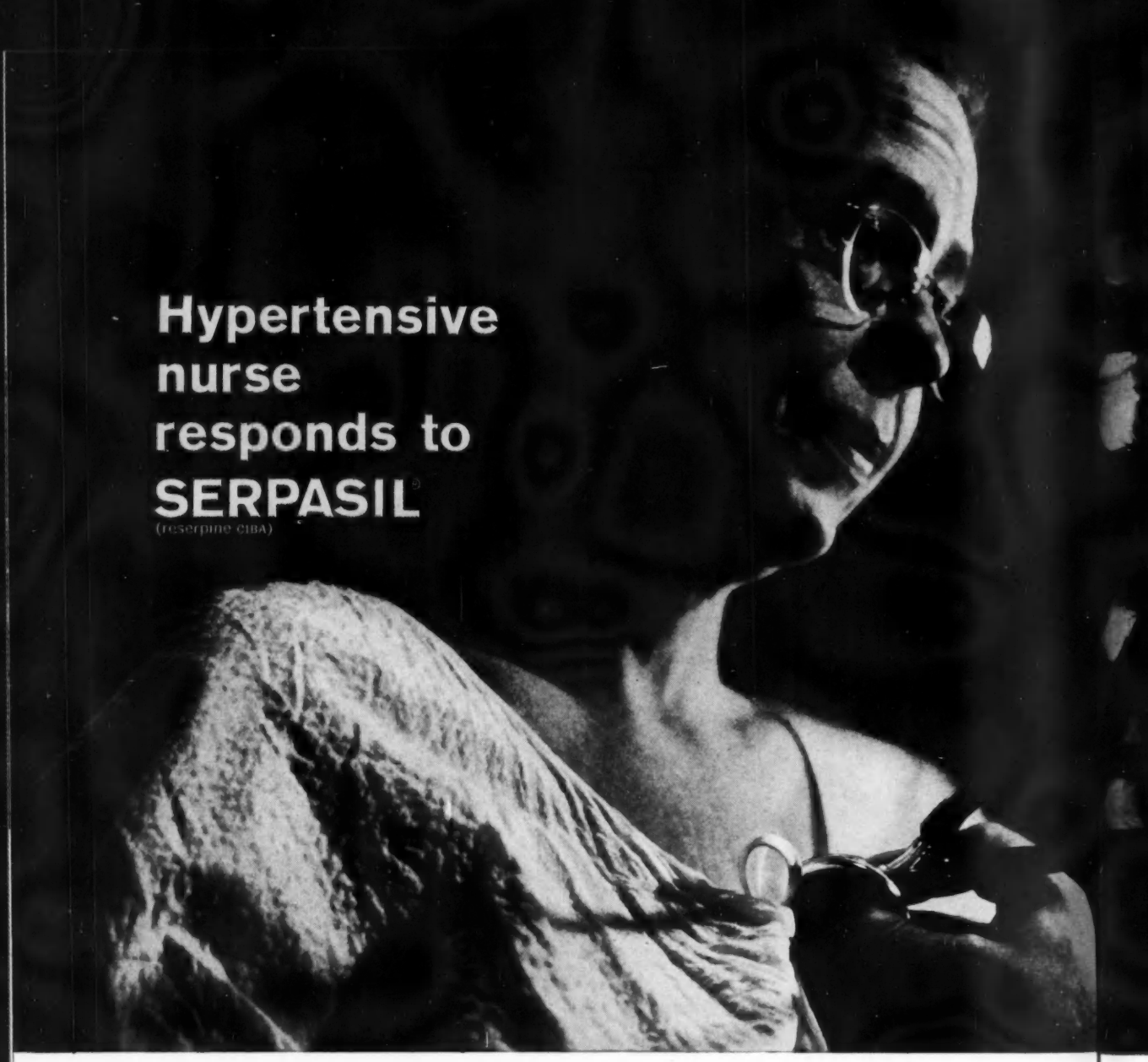


MWN's PILOT ISSUE

I must confess that when we were putting the finishing touches on that first dummy, we didn't dream that within a year we might have to list subscription rates in yen.

M M Geffen

Publisher



Hypertensive nurse responds to SERPASIL

(reserpine CIBA)

Antihypertensive and calming effects produce good results

Mrs. E. Y., age 45, is active and vigorous. She is a happy woman with many interests: antiques, baking, knitting. Trained as a nurse, she has been married 18 years and, until 7 years ago when her husband was promoted, worked in a doctor's office.

On April 8, 1959 she had a complete physical examination. There was a history of "migraine" headaches—probably due to tension—slight weight gain, and minor gynecologic problems. Laboratory findings and EKG were normal. She had mild, essential hypertension.

Her physician prescribed Serpasil—0.25 mg. at bedtime. Blood pressure responded as shown in table at right.

Her physician reported: "In view of the slight blood pressure rise [after discontinuation of Serpasil] it is probable that intermittent Serpasil therapy will be necessary indefinitely."

Calmer and normotensive, Mrs. Y. notes: "With Serpasil I don't care that the furniture doesn't get dusted every day."

BLOOD PRESSURE RECORD OF MRS. E. Y.

April 8	150/110 mm. Hg
May 10	140/90
June 12	110/80
July 20	110/70
November 11	116/70
(Serpasil discontinued)	
December 12	140/80

2/2681MK

Photos used with patient's permission.

BLOOD PRESSURE THAT GOES UP WITH STRESS OFTEN COMES DOWN WITH SERPASIL®

(reserpine CIBA)

One reason that many cases of hypertension respond to Serpasil is that many cases are associated with stress. Stress situations produce stimuli which pass through the sympathetic nerves, constricting blood vessels, and increasing heart rate. Hyperactivity of the sympathetic nervous system may elevate blood pressure; if prolonged, this may produce frank hypertension. By blocking the flow of excessive stimuli to the sympathetic nervous system, Serpasil guards against stress-induced vasoconstriction, brings blood pressure down slowly and gently.

In mild to moderate hypertension

Serpasil is basic therapy, effective alone "...in about 70 per cent of cases..."*

In severe hypertension

Serpasil is valuable as a primer. By adjusting the patient to the physiologic setting of lower pressure, it smooths the way for more potent antihypertensives.

In all grades of hypertension

Serpasil may be used as a background agent. By permitting lower dosage of more potent antihypertensives, Serpasil minimizes the incidence and severity of their side effects.

*Coan, J. P., McAlpine, J. C., and Boone, J. A.: J. South Carolina M. A. *51*:417 (Dec.) 1955.

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Complete information available on request.

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Bottles of 100 soft, soluble capsules, this actual size. Prescription only.

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NEWS

OUTLOOK

- **Million-dollar gift boosts student scholarships**
- **California MDs debate loyalty oath requirement**

Each of the eighty-six U.S. medical schools will soon be given from $10,000 to $16,000 each to be used for non-refundable scholarships. The grants—totaling $1,100,000—are being made by the Avalon Foundation (set up two decades ago by the daughter of Andrew W. Mellon) and are to be awarded on the basis of applicants' financial needs and scholastic attainments. The Foundation's gifts come to only slightly less than half the total scholarship expenditures of all American medical schools in 1959-60.

The health claims of vegetable oil manufacturers are undergoing a second look by the Food and Drug Administration. Last year, FDA demanded that references to cholesterol be removed from corn oil labels. But the American Heart Association has issued a statement supporting the view that poly-unsaturated fats as a substitute for animal fats may reduce the risk of heart attacks. As a result, the vegetable oil people are claiming the Government is wrong and should reconsider.

Prescription drug group insurance is going to get a trial run. For $1 a month per family, the Pacific National Life Assurance Company will pay for all prescriptions filled by members of a California bricklayers' union. Participating pharmacies will send bills along to Pacific National which will pay them directly.

Government approval is being sought for the marketing of a second cholesterol-lowering drug, Baxter Laboratories' "Cholixin." (The only one now on sale in the U.S. is Wm. S. Merrell Company's MER/29). The Baxter thyroid analogue has just gone on the market in Canada. According to Dr. Thomas A. Garrett, the company's medical director, "Cholixin" produces an average drop of about 25 per cent in blood cholesterol levels, and clinical studies of 1,000 patients have shown it to be "safe and effective."

The first U.S. doctor's union has been set up by physicians in the New York City Department of Health. Called the Doctors Association of the Department of Health, the organization will seek salary increases, tenure and pension rights for MDs and dentists employed by the city.

Harvard University is going to spend five years investigating the economic and administrative problems of medical care. Under a $297,000 grant from HEW, the Harvard School of Public Health will look into such matters as the impact of governmental, collective bargaining and group practice programs; current and future personnel requirements; and the role of prepayment plans.

A long-simmering dispute over the California Medical Association's loyalty oath may come to a head at the CMA's annual meeting. Last year, a San Francisco faction had hoped to get rid of the oath requiring officers and delegates to swear they don't belong to any one of some 250 subversive organizations. They failed, and the matter was turned over to the Association's council for a study to determine how other professional organizations deal with the problem. The San Franciscans now say they'll raise the loyalty oath issue again if the council decides it has gathered enough information from other groups.

Look for fireworks from the mid-April meeting of the American Academy of General Practice. United Auto Workers president Walter Reuther and AMA president Dr. E. Vincent Askey have agreed to share the same platform to discuss "The Economics of Medicine."

MEETINGS

Mar.	**28-31**	American Association of Anatomists, Chicago
Apr.	**5-8**	U.S. Public Health Service Clinical Society, Lexington, Kentucky
Apr.	**8-9**	Southwestern Society of Nuclear Medicine, Oklahoma City
Apr.	**9-12**	Tennessee State Medical Assoc., Chattanooga
Apr.	**9-14**	Amer. Industrial Health Conference, Los Angeles
Apr.	**10-12**	American Academy of Pediatrics, Wash., D. C.
Apr.	**10-13**	Southwestern Surgical Congress, St. Louis
Apr.	**10-13**	Ohio State Medical Association, Cincinnati
Apr.	**10-14**	Fed. of Amer. Soc. for Experimental Biology, Atlantic City
Apr.	**15-20**	Amer. Acad. of General Practice, Miami Beach

UPCOMING

June	**4-10**	World Congress of Psychiatry, Montreal
Sept.	**14-17**	2nd Int'l Symp. on Chemotherapy, Naples
Oct.	**4-6**	Soc. for Clinical & Experimental Hypnosis, Cleveland
Oct.	**20-24**	American Heart Association, Miami Beach

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Dosage: 1 or 2 tablets 3 or 4 times daily. The usual precautions of corticosteroid therapy should be observed. Additional information on DECAGESIC is available to physicians on request. Supplied: Bottles of 100. Each tablet contains 0.25 mg. of DECADRON (dexamethasone), 500 mg. of aspirin and 75 mg. of aluminum hydroxide (present as the dried gel). DECAGESIC and DECADRON are trademarks of Merck & Co., Inc.

*"Antidoloritic" describes the relief of pain associated with inflammation—dolor=pain, itic=associated with inflammation.

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MEDICAL WORLD NEWS
March 17, 1961 Vol. 2, No. 6

CLINICIAN GAUGES CANCER DRUG RESPONSE

Six-year study of patients with metastases provides important clues to selecting cases and tailoring therapy for best results

One of the first reported attempts to systematically relate clinical factors and response to cancer chemotherapy has just been made in a six-year study of almost 600 patients with metastases.

As a result, it may be possible to select patients more accurately for chemotherapy, determine which drug to use and predict whether the response will be favorable, says Dr. John D. Hurley, assistant professor of surgery at Marquette University School of Medicine, Milwaukee.

Especially striking is his finding that a patient with metastases from breast cancer is more likely to respond to chemotherapy if she has previously been given endocrines. The response also occurs, although not as markedly, even if the hormones have been of little benefit, he told the Central Surgical Association in St. Louis.

Dr. Hurley based this conclusion on study of 266 breast cancer patients with metastases. Among them were 160 women who had received hormones: stilbestrol for those four to five years postmenopause, testosterone for those who had been oophorectomized. Ninety-nine of these were helped by subsequent chemotherapy. But of the 106 women who received no hormone therapy, only 19 benefited from systemic anti-tumor drugs.

On the basis of these significant findings, Dr. Hurley, whose study was conducted on terminal patients at Milwaukee County Hospital, recommends that "all breast cancer patients should have a trial of endocrines before chemotherapy."

"Profiles" of the types of patients most likely to do well with chemotherapy for recurrences or metastases following breast, colon or lung cancer have been sketched by Dr. Hurley. His criteria for a favorable response include both objective decrease in tumor size and subjective feeling of improvement for a minimum period of three months.

In breast cancer, prognosis is best for a middle-aged woman, four years post-radical mastectomy, with proven soft-tumor recurrence, treated with hormones, then 5-fluorouracil (5-FU).

DR. HURLEY relates cancer prognosis to clinical factors.

"Both 5-FU (an experimental drug under development by Hoffmann-La Roche) and *Cytoxan* (Mead Johnson) have yielded useful palliation, with 5-FU giving the more prolonged and rewarding response," Dr. Hurley points out. Administered to 82 patients, 5-FU produced a good response in 42, for an average duration of 6.8 months. He noted, however, that 5-FU was the most toxic drug employed in the series. *Cytoxan* produced early benefits that "were at times dramatic, but these tended to be short-lived." Average duration in 23 of 39 patients was 4.3 months. *THIO-TEPA* (Lederle) was least toxic, and in 25 of 60 women it elicited an average response of 7.2 months.

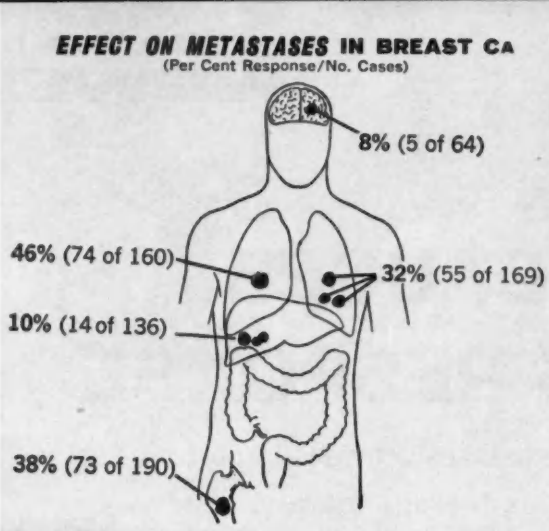
Combination drug therapy "was also impressive." In 14 of 29 women, response averaged 7.1 months, and in two of them it was 12 or more months.

In cancer of the colon, Dr. Hurley draws a different prognostic profile: a patient with two or more years post-colon resection, with regional or peritoneal spread treated by 5-FU.

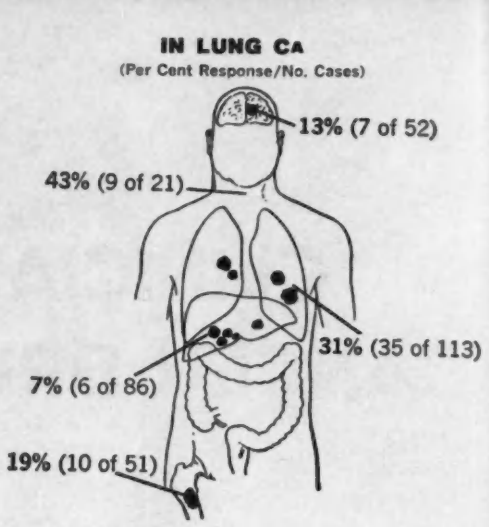
In a series of 197 men and women, 56 "obtained useful palliation" with the anti-tumor agents employed. Here, as with carcinoma of the breast, 5-FU was the most useful agent studied.

Administered to 104 patients, it benefited 35 for an average of 5.8 months, three for 12 or more months.

CONTINUED ON PAGE 14



SITE of secondary tumor is major factor in drug therapy. In some cases, soft-tissue spread produces the best response.



RESULTS of chemotherapy in lung cancer cases are most marked when secondary site is superior vena caval obstruction.

CANCER THERAPY CONTINUED

The most useful anti-tumor effect of the various drugs "was seen in local or regional recurrences (50 of 135 patients)." Other areas rarely responded.

In lung cancer, Dr. Hurley sees most benefit for a patient who has had squamous carcinoma for at least six months, with superior vena caval obstruction and regional spread, treated with combined drug therapy.

Of 134 patients in this series, 41 achieved a favorable response. The "most prolonged palliation" occurred in 7 of 20 patients who received a combination of an alkylating agent — *THIO-TEPA, Cytoxan* or nitrogen mustard, and an antibiotic—actinomycin D or mitomycin C, or an antimetabolite—6-mercaptopurine (*Purinethol,* Burroughs Wellcome) or amethopterin (*Methotrexate*, Lederle). "One patient obtained useful palliation for 26 months and one for 15 months."

THIO-TEPA alone helped 13 of 40 patients for an average of six months, two of them for a year.

In addition, "the locally or regionally confined tumors were considerably more responsive than those that had metastasized outside of the thoracic cage," he says.

The final factor of importance in this group is tumor type. "Differentiated tumors were generally more responsive than undifferentiated ones." Palliation occurred in 32 of 80 patients with squamous pulmonary carcinoma, five of 15 with adenocarcinoma and only four of 39 with undifferentiated or anaplastic carcinoma. ■

CANCER CELLS IN SEARCH

Their growth into metastases may depend on the therapy used for the primary tumor

Most cancers release malignant cells more or less continuously into the lymphatic or vascular system. Yet autopsies of cancer patients reveal that few of these cells survive to form metastases.

Some investigators maintain that tumor cell survival is determined by local tissue factors at the site of cell lodgment. Others believe that metastases depend on the mechanical vagaries of the circulatory system. But clinical evidence for either view has been scant.

Two noted cancer experts from Roswell Park Memorial Institute, Buffalo, N. Y., have now made a strong case for the "environment" school. In a report in *Surgery, Obstetrics and Gynecology,* Drs. Thomas Dao and George E. Moore point out that the pattern of metastases development can sometimes be traced to the therapy employed for the primary tumor — especially if the therapy affects local tissue environment.

In certain patients with breast cancer following x-ray therapy, metastases tend to concentrate in the irradiated area, according to Drs. Dao and Moore. Following surgery which may involve lymph node dissection for malignant lesions of the terminal part of the limb, metastases are seen to develop distal to the site of operation.

Both of these procedures, they suggest, set up a favorable environment for tumor cell survival and subsequent growth, apparently by altering the flow of blood or lymphatic fluids in certain areas. However, more than a mere mechanical blockage appears to be involved. Growth finally depends on other undefined changes in the local tissue milieu.

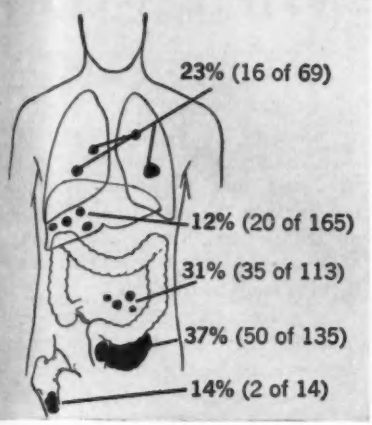
Patterns of Metastases

As an example of this type of case, Drs. Dao and Moore describe a patient who received radiation in the left anterior chest and supraclavicular axillary regions two months following a left radical mastectomy. A year after irradiation, the patient had recurrent skin metastases over the exposed portion of the left chest wall. A lump was also found in the right breast. X-ray therapy was repeated over the left anterior chest wall and extended to the right breast. Examination five months later revealed even more and larger dermal metastases involving not only the left anterior part of the chest wall but the shoulder and subscapular area.

"The skin metastases were almost entirely confined within the area of roentgen ray ports and along the margins of the radiation dermatitis."

Discussing metastases after lymph node dissection, Drs. Dao and Moore point out that multiple superficial

IN COLON CA
(Per Cent Response/No. Cases)



PROGNOSIS for colon cancer patients is improved if spread is regional.

OF A SITE

metastases sometimes develop in the legs following groin dissections. "It would seem strange—unless the local environment has been altered so as to favor tumor-cell growth—that all of the metastases in these cases are located in the leg below the level of the dissection."

Apparently the dissection, "by disrupting the major lymphatic vessels that drain the limb, has caused tumor cells to be arrested in the lymphatics or capillaries and has thus produced a favorable environment for their survival."

Moreover, they note that metastases sometime develop in this pattern after a lapse of months or years. This observation, they declare, throws doubt on the statement that "the moment of truth" for tumor cells—when they must either survive or perish—occurs when they first lodge in a capillary bed.

Evidently "tumor cells may remain dormant for months or years and subsequently multiply and kill the host." However, the factors which terminate dormancy and reinstate cell growth remain unknown. Animal studies show that either surgery or cortisone therapy can activate dormant cells. Drs. Dao and Moore suggest that the cataloguing of clinical phenomena which bring about changes in the local environment of tumor cells might lead to the discovery of factors which result in accelerated tumor growth. ■

NATION HIT BY RECORD HEPATITIS OUTBREAK

USPHS experts predict that this year's cases will even top the 50,000 reported in 1954

The greatest siege of hepatitis since it became a reportable disease more than nine years ago is gripping the nation from coast to coast. Cases are running more than 100 per cent above 1960 and topping 1954's peak.

At the end of the first seven weeks of this year, cases had hit the 11,455 mark. This compares with only 5,128 in 1960 and a five-year median of just 3,513. As predicted in MEDICAL WORLD NEWS (Jan. 20) by Dr. Alexander Langmuir, chief epidemiologist of the Public Health Service's Communicable Disease Center, every section of the country is being hard hit. The totals in the Mountain and East South Central states have soared well above the national average, but some of the excess might be due merely to better reporting.

The Communicable Disease Center in Atlanta reported that the explosive increase in cases this winter will shoot 1961 well beyond the 41,000 cases reported in 1960 and even the 1954 record of 50,000.

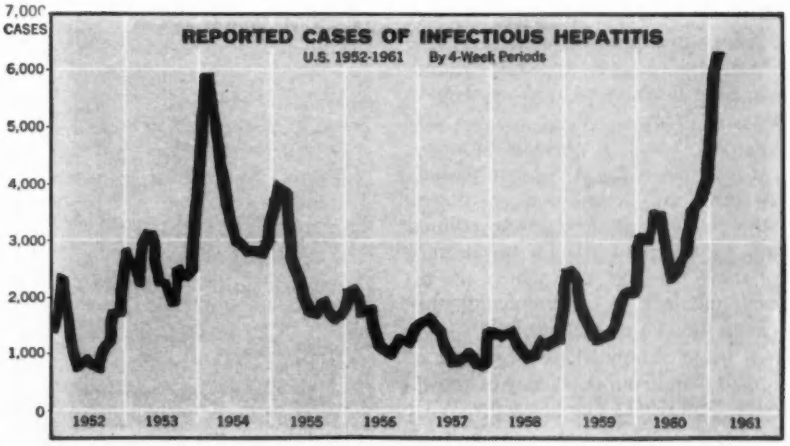
Hepatitis rises and falls in six and seven-year cycles and this year could be the new cyclical peak. But the CDC experts say that the case rates may climb even higher next winter, before the trend turns downward.

These same authorities predict that the present seasonal upsurge should begin tapering off by the middle or end of March. The yearly peaks usually come in March, although the high point has sometimes been reached in January or February.

Two of the hardest hit states in the country have been Tennessee (905 cases in seven weeks) and Kentucky (701 cases). Kentucky also suffered heavily last year. Other high incidence areas: Ohio with 906 cases, California 835, Pennsylvania 652, New York 651, Michigan 563, Texas 485, Illinois 336, Alabama 313, Colorado 301, Indiana 287, New Jersey 276, Minnesota 278, Missouri 264, North Carolina 268, Iowa 256 and Oregon 252.

Cases reported for the first week of 1961 totaled 1,014. They then rose rapidly to more than 1,800 in the third week and held close to this level through the seventh week.

There have been no sharply defined outbreaks except where there have also been unusual circumstances. The most spectacular of these occurred in Pascagoula, Miss., where 32 cases were linked with eating raw oysters. These, it was learned, came from a bed in the Pascagoula River, which was temporarily polluted. This corroborated a famous case in Sweden where contaminated oysters were also incriminated in an outbreak of hepatitis. Although food has often been suspected as a source, it has seldom been identified positively. ■



MDs AND DOs EXPLORE SCIENTIFIC POINTS OF

A small group of physicians and doctors of osteopathy meet privately for the first time to seek ways of furthering a rapprochement between the two branches of healing arts

Last spring the Rockefeller Brothers Fund gave to osteopathic medicine a grant of $500,000 for research and teaching. Apart from the fact that this was one of the largest philanthropic gifts to osteopathy, the grant carried a significant stipulation: "That new avenues of cooperation with colleagues in other branches of medicine be opened."

One of these new avenues has just been explored in New York by nine osteopaths and seven physicians, who sat together in private for a day and a half and discussed ways to further a rapprochement between the two branches of the healing arts.

In sharp distinction to many previous exchanges on the public platform, this private meeting of osteopathy and medicine was marked by good will and friendly, if pointed, discussion.

Document the Osteopathic Lesion

All agreed that the purpose of the meeting was mutual respect, achieved by mutual understanding. All stuck to an unwritten rule: the question at hand was scientific, not political. And all were sure of the basic issue: the difficulty lies in the simple fact that osteopathy and medicine are two professions approaching the same goal from different angles. These two lines must either merge or, at least, intersect somewhere, if the two groups are to be allies. Each side must "give a little." The osteopath must try harder to make his approach understandable in the physician's terms, while the doctor must listen to what the osteopath is trying to say.

A most serious obstacle to amity, for instance, is the American Medical Association's designation of osteopathy as a cult, the osteopaths pointed out. MDs agreed: "The very existence of the word 'cult' is a sign of the illease and lack of communication between the two disciplines."

"I don't know where we are more united than in our deficiency of knowledge," one MD emphasized. "What we need is to have some notion of the ability of the osteopath to find and diagnose the 'osteopathic lesion.' Put it down on paper and document it for the clinician; then we will find that we are talking about diseases and not arguing about osteopathic medicine."

It was on this point of defining the osteopathic lesion—and the DOs way of finding and treating it—that the conferees had the most trouble. Medical participants proposed a course for the osteopaths:

"Describe the osteopathic lesion in terms of the basic sciences, develop a therapeutic rationale similar to that of other therapies, and use identical instruments of evaluation."

The DOs had a ready reply:

"Perhaps it is not quite fair to ask the doctor of osteopathy to talk about the osteopathic lesion in medicine's language. The osteopath deals with a realm of experience not often shared by the MD, and there is no substitute for shared experience. As long as organizational barriers stand in the way, the MD is prevented from sharing this experience.

"What is it the DO feels?" the osteopaths were asked. "It surely is not a figment of his imagination. Osteopathy seems to be something that medicine doesn't recognize. People who have some medical orientation should try to find out what it is and see if it should not be made a part of medicine."

This offer was immediately matched by a suggestion from the osteopaths that "we should be as willing to open the door to the MD for graduate instruction in osteopathy as MDs should be in letting the DO undertake medical training."

However, DOs pointed out, there *is* a difference in emphasis "on the problems of health and disease between the two groups. The neuromuscular-skeletal system is affected by disease. This is the basis of the osteopathic lesion. The rationale of manipulative therapy is not so much a therapy as an approach to a disease process, and there is not a single clinical entity in which it may not be important. It is a strategy of raising an individual's sense of wellness."

But this definition was not wholly satisfactory to medical panelists. "We must make the attempt to distinguish between the general effects and the specific effects of therapy," they insisted. "We cannot get certainty, but there should be some attempt to construct clinical experiments as we go along. These must be carefully designed efforts so that an attempt can be made to assess the therapeutic situation. By this means we can make a judgment—not a final judgment, but at least a working judgment of the

SIXTEEN-MEMBER PANEL

MEDICAL PHYSICIANS

William F. Ashe, Chairman, Department of Preventive Medicine, Ohio State University, Columbus, Ohio.

Halbert L. Dunn, Special Assistant on Aging, Bureau of State Services, Public Health Service, Washington, D. C.

James L. Goddard, Civil Air Surgeon, Federal Aviation Agency, Washington, D. C.

Herman E. Hilleboe, Commissioner of Health, New York State, Albany, N. Y.

Hollis Ingraham, New York State Department of Health, Albany, N. Y.

William N. Hubbard, Jr., Dean, University of Michigan Medical School, Ann Arbor, Mich.

Hugh Leavell, Professor of Public Health Practice, Harvard School of Public Health, Boston, Mass.

OSTEOPATHIC PHYSICIANS

John M. Andrews, Chairman, Department of Physical Medicine and Rehabilitation, College of Osteopathic Physicians and Surgeons, Los Angeles, Calif.

J. S. Denslow, Director of Research, Kirksville College of Osteopathy and Surgery, Kirksville, Mo.

Allan A. Eggleston, Member, Board of Directors, Foundation for Research, Montreal, Canada.

Murray Goldstein, Medical Director, Public Health Service, Washington, D. C.

J. Marshall Hoag, Medical Director, Le Roy Hospital, New York, N. Y.

Irwin M. Korr, (Ph.D.) Head, Department of Physiological Sciences, Kirksville College of Osteopathy and Surgery, Kirksville, Mo.

R. N. MacBain, President, Chicago College of Osteopathy, Chicago, Ill.

George W. Northup, Moderator of the meeting and a past-president, American Osteopathic Association.

R. McFarlane Tilley, Dean, Kirksville College of Osteopathy and Surgery, Kirksville, Mo.

OF VIEW

effectiveness or otherwise of what we are doing."

During the day and a half meeting, there were occasional notes of bitterness. It was pointed out, for example, that "when the United States faced a shortage of physicians they went to foreign trained doctors and ignored the osteopathic physician. Those who have not had as good a medical training were given an opportunity over qualified men."

To End the Cold War

The atmosphere in general, however, was one of eagerness to break the long cold war. To this end, these recommendations were offered:

- Funds should be made available for osteopathic literature. There will be no difficulty getting journals into the libraries and they will certainly be read once there.
- There should be a system of exchange professorships between MDs and DOs.
- The possibility of further education for osteopaths, perhaps at the Veterans Administration hospitals, should be explored.
- Osteopaths should participate in meetings of national interest.
- There should be an exchange of top research men. No medical school could object to this. This is immediately practicable in physiology and neurology where, at the Kirksville College, a team has made a start on physiological studies that may eventually spell out the osteopathic lesion.
- There should be further meetings such as this, and they should include deans of osteopathic as well as medical schools, and sessions with orthopedic surgeons, rehabilitation authorities and experts in occupational medicine. [Two more such meetings are to be held this year.]

But where is all this understanding to lead?

"Ultimately we must decide," conferees concluded, "whether we are working toward a situation in which a physician has some knowledge of osteopathy, or whether we intend to have two professions, each separate and distinct.

"Ultimately we must decide whether this is to be a federated or a treaty existence." ■

PROTESTING MDs seek boycott. Sign reads: "Save Public Health from Collapse."

JAPANESE PHYSICIANS STAGE A ONE-DAY STRIKE

MDs threaten to pull out of health plan unless they get a 30 per cent rise in fees

Patients at a clinic in the Tokyo suburb of Denenchofu were halted at the door before they could remove their shoes and step into the reception room.

"Gomen nasai," said an apologetic nurse, with a deep bow. "So sorry, but the doctor won't be in today. He has gone to the protest rally."

The scene was repeated at doctors' offices throughout the city, as more than 8,000 physicians converged on Tokyo's Hibiya Hall. Even as an outbreak of B-type influenza closed schools in Japan's capital, doctors were staging a one-day strike to demand a 30 per cent rise in fees and simplified administration of the nation's health insurance program.

The Tokyo Medical Association, which staged the rally and march to the steps of the Health and Welfare Ministry, had the support of the Japan Medical Association, which has threatened to pull its more than 84,000 members out of the National Health Insurance program unless its demands are met.

Thus far, the Ministry of Health and Welfare is resisting the doctors, but it is caught in a crossfire.

Hospital personnel object to starting salaries of $28 a month for doctors, $22.50 for nurses, $21.50 for clerks and $22 for x-ray technicians and dieticians.

The Federation of Medical Workers' Unions claims the Labor Standards Law is violated openly in most hospitals. Nurses supposed to be responsible for four beds must take care of 15, and are paid for less than a quarter of the overtime they work.

The Japan Medical Association's members operate their own clinics or private hospitals. (In Japan, a clinic has less than 20 beds; over 20, it's a hospital.) The Association insists that until government health insurance fees and restrictions, covering some 90 per cent of their patients, are improved, it cannot raise salaries.

The Health and Welfare Ministry is being assaulted from another direction. The Federation of Health Insurance Unions, representing 13 million workers insured under the law, has staged protest parades to denounce any move to increase fees for medical care.

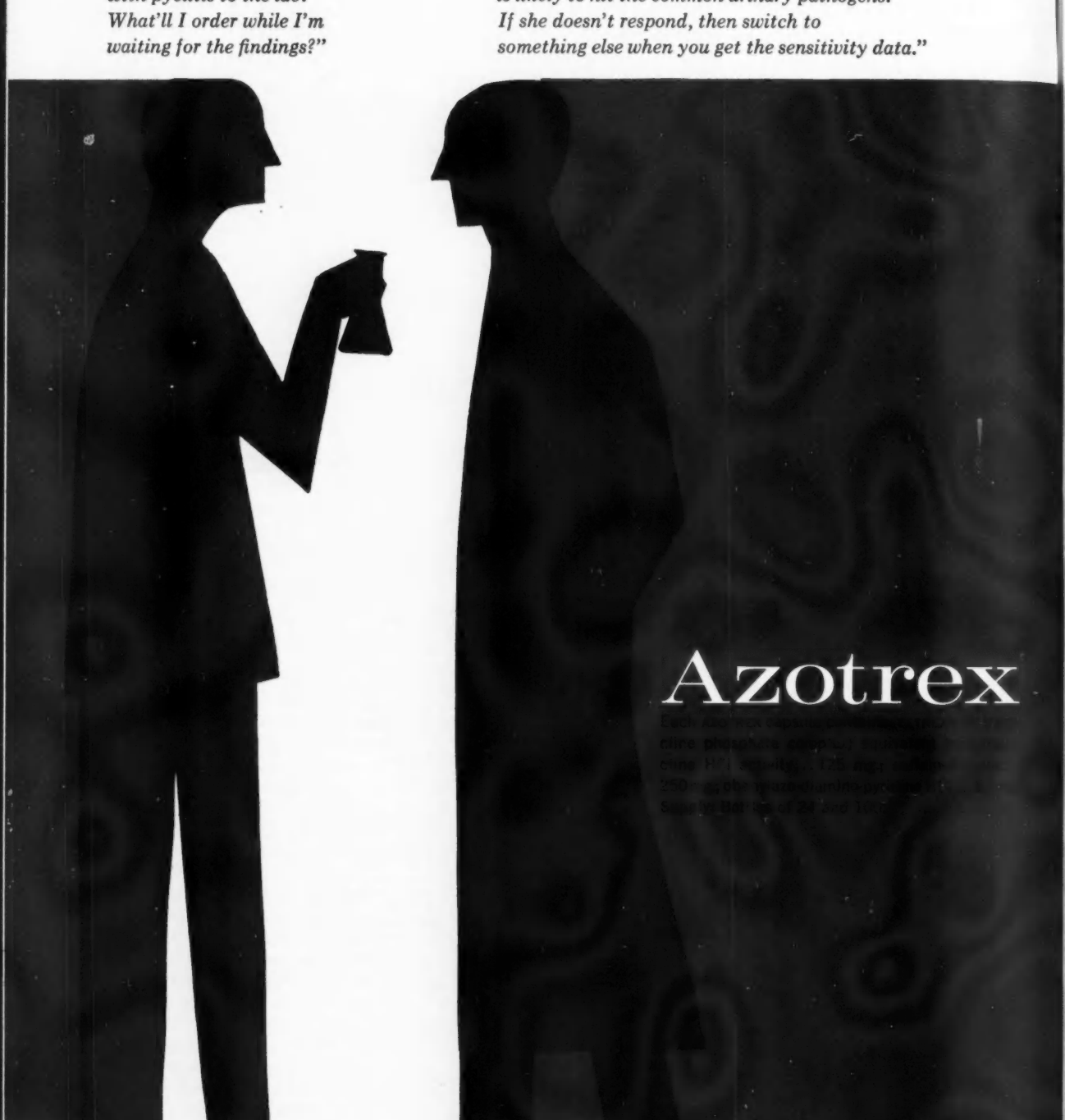
FHIU, moreover, has the support of the militantly leftist Sohyo, or Japan Federation of Labor Unions, and the Japan Socialist Party.

In the budget announced last month, Prime Minister Hayato

CONTINUED ON PAGE 19

"I'm sending this urine specimen from the patient with pyelitis to the lab. What'll I order while I'm waiting for the findings?"

"I'd use AZOTREX. The azo dye will give her quick symptomatic relief. The sulfa-tetracycline combination is likely to hit the common urinary pathogens. If she doesn't respond, then switch to something else when you get the sensitivity data."



DOCTORS STRIKE CONTINUED

Ikeda's government proposed a ten per cent hike in fees, with no change in the present system of accounting, under which hospitals make one charge and clinics and physicians another. The compromise promptly was rejected both by MDs and the unions.

The only organization satisfied with the government offer is the Japan Hospital Association, whose members are the public hospitals and their medical staffs.

"The hospitals benefit under the dual-fee system, which enables them to charge $11.10 for an appendectomy and $.80 a day for inpatient care, whereas a clinic can charge only $8.50 for the operation and $.70 a day," Dr. Taro Takemi, JMA president, told MEDICAL WORLD NEWS. "We don't think size of a building should determine cost of treatment."

Dual System Operates

The dual-fee system originated in 1958, when the Ministry revised the scale for payment under the health insurance laws. Fees are determined on a point basis, with one point worth ten yen (3.6 cents). The government sought to do away with the previous point system, under which doctors were paid for their services and also for the medications they prescribed and sold. JMA protested the move, and two schedules were adopted.

Once a year, each physician or institution indicates whether it wishes to be paid under Table A or Table B for its insurance patients. Table B gives less points for consultation and treatment, but more for injections and medication. Most hospitals now use Table A, as more of their income is from inpatient care. Most clinics and GPs cling to Table B.

"Government hospitals tend to hospitalize patients long after they could have been on outpatient treatment," charged Dr. Takemi. "Coming under government control, they have to use the A Table, which pays more for hospitalization than for cures."

"Doctors should not be drug salesmen," retorted Dr. Toshiro Matsuura, speaking for the Ministry's Bureau of Social Insurance. "The physician should be paid for his diagnostic, consultative and treatment skills, not for how many drugs he prescribes."

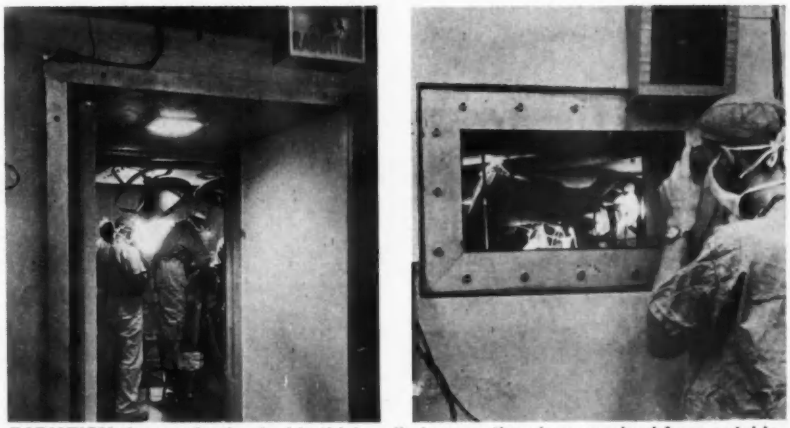
The Hospital Association has accepted the government's ten per cent fee hike, reportedly with an assurance that subsidies for hospital operation will be forthcoming. JMA insists that doubling present fees would be justified, and that 30 per cent is the least increase it will accept.

JMA also contends health insurance unions hold more than $1 billion in employers' and workers' contributions, and are using these funds to finance union activities and strengthen unions by building rest homes and recreation hotels. The law specifies the money can be used either for medical treatment or for preventive medical care.

The Japan Medical Workers' Federation pulled its workers out of 106 hospitals recently in the third walkout this year. Serving notice they will no longer be put off, the Federation executives agreed to take their unions into Sohyo in April or May. The giant Sohyo promised a "unified struggle" to obtain higher wages while fighting "attempts to increase the public's share of medical fees."

In 1958, the Ministry of Health and Welfare bought an uneasy truce by compromising on the two point systems for health insurance fees. This year, with the insurance system expanding to cover all 91 million Japanese by April 1, the situation is vastly more complex—and potentially more explosive. ■

NEUTRONS BOMBARD BRAIN TUMOR



RADIATION therapy begins inside thick-walled room, then is supervised from outside.

Although modern neurosurgery is capable of removing the major portion of malignant tumors in the brain, tiny bits of cancerous extension may remain as seeds of regrowth.

In an attempt to destroy these seeds, a Massachusetts Institute of Technology team has devised a method that enables direct "neutron bombardment" of the brain through an opening in the skull.

When neutrons strike certain substances—such as boron compounds—they emit high-speed, short-lived subatomic particles. Boron, used by the MIT team, has the vastly useful, unexplained property of concentrating in cancer cells rather than in healthy tissue. Thus, the destructive power of "alpha" particles emitted by the neutron beam is almost exclusively limited to cancerous tissue.

The new technique using the MIT reactor was devised by Dr. William G. Sweet, neurosurgeon at Massachusetts General Hospital, whose team conceived a somewhat similar method at Brookhaven National Laboratory on Long Island, N. Y.

At Brookhaven, however, the reactor used was limited to treatment from the side, the skull was not opened, and a stronger neutron flow was used.

Actual radiation lasts between 30 and 45 minutes, but the entire procedure takes five to seven hours. During treatment, remote controls are used for anesthesia and recording of heart action and breathing. The patient is observed through a window in the shielded room.

In all eight cases treated so far, surgical removal of most of the tumor preceded neutron therapy. Results of the therapy have not been evaluated, but Dr. Sweet believes that direct action on the brain may prove more effective than the previous method. ■

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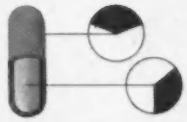


first – the outer layer dissolves within minutes to produce 3 to 4 hours of relief **then** – the core disintegrates to give 3 to 4 more hours of relief.

Formula: Each MSC Triaminic timed-release Tablet provides: Phenylpropanolamine HCl, 50 mg.; Pheniramine maleate, 25 mg.; Pyrilamine maleate, 25 mg.; Methscopolamine nitrate, 4 mg.
Dosage: Adults and children over 12 – one tablet in the morning, midafternoon, and before retiring. These tablets should be swallowed whole to preserve their timed-release action. Supplied: Bottles of 50 tablets.
Caution: The usual precautionary measures for antihistamines and sympathomimetic agents should be observed. Contraindicated in the presence of glaucoma and in elderly patients with prostatic hypertrophy.

$50 MILLION RACKET IN COUNTERFEIT DRUGS

Growing traffic in illicit prescription pills could endanger MDs, patients and ethical drug makers

Prescription drugs at drastically cut-rate prices can be a bad bargain for both physicians and patients. The drugs may be counterfeit.

Experts say trade-name drug counterfeiting—an estimated $50 million business in 1960—is on the rise. It's biting into the economic health of the pharmaceutical industry, endangering patient's lives and putting doctors in a particularly risky position. A patient may not respond to a prescription, and the MD will not know why. Some patients may become seriously ill because of adulterated or polluted drugs. And if a malpractice suit ensues, there is no manufacturer to assume the responsibility.

There is no easy way for doctor or patient to know that a drug is a fake. It takes careful lab analysis—a kind of "ballistics" for pills—to distinguish them from the genuine article.

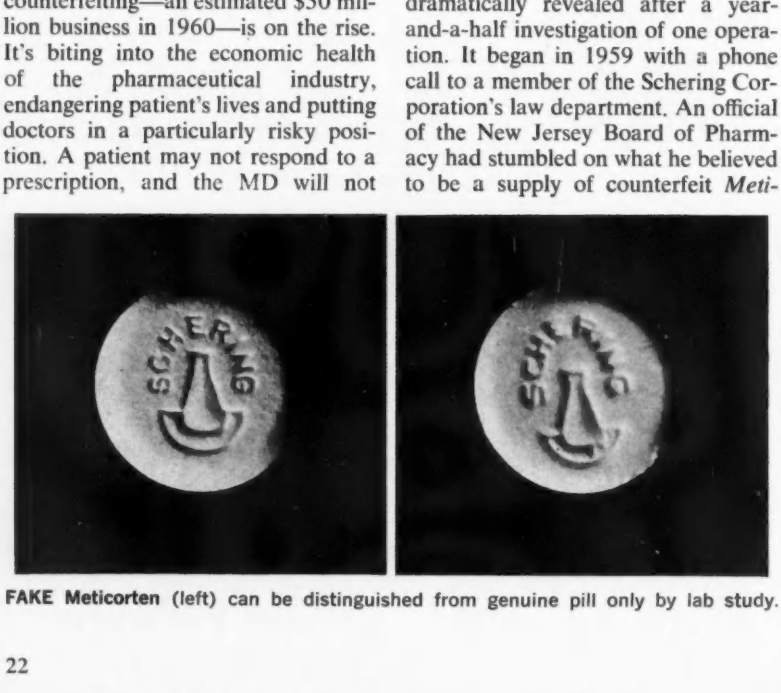
Drug counterfeiting is an old business, but only recently has it become big business. Just *how* big was most dramatically revealed after a year-and-a-half investigation of one operation. It began in 1959 with a phone call to a member of the Schering Corporation's law department. An official of the New Jersey Board of Pharmacy had stumbled on what he believed to be a supply of counterfeit *Meticorten* tablets. He knew only that a pharmacist had bought the pills at a "considerably reduced price from a shady source operating from a car."

The pills looked like *Meticorten.* They were the right size, shape and texture. They bore the distinctive company imprint. But laboratory analysis showed they were simply carefully imprinted copies.

Other tips soon reached other pharmaceutical firms, and a team of private investigators was hired to track down the sources. Evidence piled up as the Food and Drug Administration and local and state agencies joined the case. A "shopper" found five of fifteen drug stores in one area were dispensing counterfeit drugs; four more were selling mixtures of genuine and counterfeit pills. Investigators made contact with a man who had bought 150,000 counterfeit samples of seven different drugs—all from a single manufacturer.

Everything pointed to the General Pharmacal Company in Hoboken, N. J., a firm known to be a producer of generic-equivalent drugs whose catalogue boasted: "Uniform tablets from batch to batch. Laboratory controlled. All formulations kept strictly confidential."

A stake-out was established across the street from the company, housed on the seventh and eighth floors of a ten-story building. The stake-out



FAKE Meticorten (left) can be distinguished from genuine pill only by lab study.

learned that the elevator was kept at the seventh floor all day. When someone wanted admittance, he rang a bell at the street level and waited until he was identified from the seventh floor. Then the elevator was sent down; it would not go down for anyone who appeared suspect.

After two weeks of surveillance, a search warrant was issued. On June 27, 1960, a person known to General Pharmacal rang the elevator bell, was recognized, and the elevator descended. When the doors opened, state, county and city detectives and state health officials swarmed on.

'Grossly Insanitary'

Upstairs, they found a rat-infested, roach-ridden, filth-encrusted pill "still." Thousands of pirated pills of Wyeth, Schering, Wallace, CIBA, and Merck Sharp & Dohme were confiscated, as well as the all-important counterfeit dies.

"The spurious products," says Milton Ruth, chief of New Jersey's Bureau of Food and Drugs, "were manufactured under grossly insanitary conditions, without quality controls, and usually carried lesser proportions of the essential drugs."

General Pharmacal, it is estimated, had been counterfeiting pills for about two years, grossing $50,000 a month. Millions of tablets were reaching an unsuspecting public.

Following the Hoboken raid and the closing of General Pharmacal, drug companies warned pharmacists throughout the country. Editorials began appearing in medical and pharmaceutical journals, and counterfeit prescription drugs were seized at pharmacies in the District of Columbia, Kansas City and North Carolina.

A New Jersey truck driver, Michaelangelo "Big Al" Contino, was apprehended and charged with pushing counterfeit drugs. So was Martin Cohen, identified as having a record of narcotics convictions. In New York City, Ludwig Spandau and Seymour Blau were convicted and sentenced on charges of conspiring to violate the Federal Food Drug and Cosmetic Act. They had used the facilities of a legitimate drug manufacturer—after working hours—to reproduce *Miltown* and *Equanil* tablets that were substantially lower in strength than the real drugs.

Drug counterfeiters, while apparently not involved in any nationwide "ring," follow a general pattern of operation, according to the FDA. Most of them use generic-name and legitimate drug manufacturing operations as a cover. They ship their drugs by air, truck or rail to avoid postal inspection, and their shipments bear fraudulent labels such as "machine tools" or "glass beads." Salesmen often carry genuine drugs in the front of the car and the counterfeit pills in the trunk.

Despite the ease with which many drugs can be duplicated, certain types are never counterfeited. Antibiotics are too costly to produce, and Lilly's parabolic capsule, Parke-Davis' banded capsule and Schering's *Coricidin* are too complex to copy.

Pharmaceutical manufacturers are putting this knowledge to use, even though they face increased production costs. Some are designing harder-to-copy tablets, some are using mottled pill colors, and others have set up full-time "product protection" departments. Numerous manufacturers rely on secret and harmless tracers.

This makes counterfeit drugs easier to identify, but first they have to be found and the counterfeiters caught. This is not so easy.

Wary of Publicity

Both the legal authorities and the drug houses, first of all, are wary of publicity about counterfeiting. They've been reluctant to seek publicity which might help expose counterfeiters—because they fear it will undermine public confidence in *all* prescription drugs.

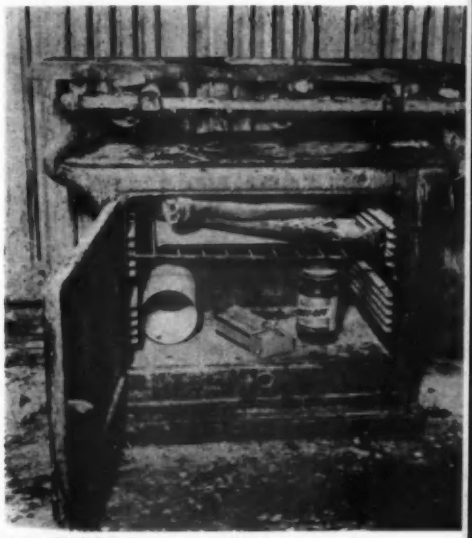
Many observers feel Federal and state laws are ineffective. The FDA, however, contends the Federal law contains ample provisions for handling the problem; there is no indication right now that the FDA will ask for tighter legislation.

But General Pharmacal may be a case in point. Though the drug companies had a clear case of trademark infringement, this is a civil matter. To bring a criminal charge against General Pharmacal, it was necessary to dig out an obscure 1898 New Jersey law that makes it a crime to manufacture or sell goods of any kind which falsely bear the "stamps or labels" of another company.

State laws vary, however. In Illi-

CONTINUED ON PAGE 25

MIXING ROOM of General Pharmacal Company has vats, rats and roaches.



GAS RANGE is among dirty discoveries made during raid on the N. J. factory.

WORK BENCH crusted with grime is found on seventh floor pill "still."

COUNTERFEIT DRUGS CONTINUED

nois, for example, an embargo law allows the seizure, retention and examination of suspect drugs. If within ten days, however, the possessor of suspect drugs agrees to destroy them in the presence of Government inspectors, no legal action is taken. Americio Scalla of Chicago was caught with 900,000 tablets of assorted drugs, including some allegedly bought from General Pharmacal. Scalla destroyed the material in the presence of FDA and Illinois inspectors and no action has been taken. (FDA suggests this is not the end of the matter.)

Lack of Evidence

Under Federal law, FDA can bring charges against counterfeiters engaging in interstate commerce who: 1) market a new drug without an effective new drug application, 2) sell the product under the name of another drug, or 3) sell improperly labelled drugs. In the case of General Pharmacal, however, five visits were made by FDA inspectors in seven years. Other than finding "sloppy housekeeping," and seizing three items of thyroid preparation in 1959, FDA said it did not uncover the type of evidence which would support a Federal action, and nothing which "in our judgment" called for a report to the state health department.

One of the best ways of slowing counterfeit traffic, some observers feel, is by exerting moral pressure on those few pharmacists who "have larceny in their hearts." An overwhelming majority of pharmacists deal only with legitimate distributors. But those who buy counterfeits, investigators say, know what they're buying and are "willing accomplices."

Whether drug counterfeiting can be stamped out altogether is questionable. The Food and Drug Administration reports that pressure already brought to bear has driven many counterfeiters deeper underground. Tipsters report that "hot" drugs are harder to come by. But FDA investigators concede this is a temporary effect. New counterfeit tablets are already springing up across the country, and it is known that dozens of counterfeit dies are "at large."

Drug counterfeiting can be likened to many diseases: Control is possible, but eradication improbable. ■

SUPREME COURT HEARS BIRTH CONTROL PLEAS

Under examination by high court, attorneys defend the rights of state and doctor

Connecticut's ban on contraceptives may be the only situation "in law or medicine" where a doctor is prevented from giving needed advice to a patient whose life may be threatened.

Supreme Court justices questioned attorneys on this point during opening arguments in a case brought by Yale gynecologist C. Lee Buxton and two of his women patients. The law makes it illegal for a doctor to prescribe—or a patient to use—contraceptive devices (MWN, Sept. 9 and Jan. 6).

Connecticut's Assistant Attorney General, Raymond J. Cannon, admitted he knew of no other similar restriction on medical practice.

"I can't think of one either, and I wondered if you could," commented Chief Justice Earl Warren.

The Assistant Attorney General argued, however, that his state has a right to bar a person from medical treatment that would prevent pregnancy, even if it is a hazard to her life and health.

"It is proper for the legislature to determine what is the greater good and how to accomplish it," he said. "There are few statutes that don't hurt in some way or other." Furthermore, he added, "there are proper ways to prevent conception through a natural method we call rhythm."

Rhythm Method Opposed

In rebuttal, Professor Fowler Harper of Yale—who represents Dr. Buxton and his patients — cited statistics showing that the medical profession has rejected both rhythm and abstinence as methods of preventing conception.

Mr. Cannon challenged this view, stating that the profession is not necessarily "unanimous" in the belief that the law is a menace to women's lives and that "no alternative exists except one that is worse than the disease."

However, Mrs. Harriet F. Pilpel, New York attorney representing the Planned Parenthood Federation of America as "friend of the court," said it is the overwhelming consensus of medical opinion that contraception is "demanded" in certain cases.

"Are you saying," asked Justice Felix Frankfurter, "that whenever you can present to the court the overwhelming opinion of the medical profession, that it suffices to invalidate a law?"

"No," Mrs. Pilpel replied. "But when most of the states and the Federal Government have followed medical opinion in such a matter, it becomes the duty of the state to assert a rational basis for the statute."

Sterilization 'Bad Medicine'

Justice Frankfurter suggested sterilization as an alternative in life-and-death cases, and was told by Mrs. Pilpel that "this is bad medicine because the woman's condition may be remedied in the future with the advance of medical science. Sterilization is irreversible."

The question of freedom of religion, which had not previously been raised in this case, was brought up by Justice Potter Stewart. Asked if religion does enter, Professor Harper said it "indeed" does, although "there is nothing inconsistent between the law and the particular religion of the persons involved."

Prof. Harper also noted that most Protestant denominations have approved artificial methods of birth control and have taken the position that it is the moral responsibility of parents to space their children wisely.

Perhaps "there is a power outside the electoral power which coerces the legislature to take the minority view in order not to offend the minority," Justice Frankfurter suggested. Assistant Attorney General Cannon insisted that this was not the case as far as Connecticut was concerned.

"Then this represents the majority view of the people who send back legislators who don't want to change the law?" Justice Frankfurter asked.

"I believe it does," Cannon replied.

The court is expected to hand down an opinion on the case sometime before it adjourns in late June. ■

What's she doing that's of medical interest?

She's drinking a glass of pure Florida orange juice. And that's important to her physician for several reasons.

How your patients obtain their vitamins or any of the other nutrients found in citrus fruits is of great medical interest—considering the fact there are so many wrong ways of doing it, so many substitutes and imitations for the real thing.

Actually, there's no better way for this young lady to obtain her vitamin C than by doing just what she is doing, for there's no better source than oranges and grapefruit ripened in the Florida sunshine. There's no substitute for the result of nature's own mysterious chemistry, flourishing in the warmth of this luxurious peninsula.

An obvious truth, you might say, but not so obvious to the parents of many teen-agers.

We know that a tall glass of orange juice is just about the best thing they can reach for when they raid the refrigerator. We also know that if you encourage this refreshing and healthful habit among your young patients — and for that matter, your patients of any age — you'll be helping them to the finest between-meals drink there is.

Nothing has ever matched the quality of Florida citrus—watched over as it is by a State Commission that enforces the world's highest standards for quality in fresh, frozen, canned or cartoned citrus fruits and juices.

That's why the young lady's activities are of medical interest.

ANTICOAGULANTS ON A LARGE SCALE

A practical program of lifetime anticoagulant therapy may be built on a new two-minute 'thrombotest' currently being used in Norway and on a trial basis in the U. S.

Every day in Oslo, Norway, 60 persons report to the University Hospital's anticoagulant clinic for a two-minute "thrombotest." At the same time 30 blood samples arrive by mail and are similarly tested. Another 60 inpatients a day receive the same test, raising the clinic's total monthly load to about 3,700. Most of these patients will be maintained on anticoagulants for the rest of their lives.

The two-minute test is based on a new "all-in-one" lyophilized agent developed by Dr. P. A. Owren, head of the medical department and professor of medicine at the University of Oslo. He believes the incidence of atherosclerotic disease in the world demands "a practical program for making permanent anticoagulant therapy available on a large scale."

The key word is control. Used in Norway and other Scandinavian countries for the last two years, as well as in Great Britain, Dr. Owren's new procedure seems to provide reliable and rapid management. It is now being tested in 50 U.S. clinics. The reagent is vacuum-sealed in ampules. Reconstituted, it measures the clotting activity in the intrinsic and extrinsic coagulation systems in capillary or citrated venous blood and in citrated plasma.

One Technician, 15 Patients

That makes it the only test sensitive to depression of factor IX (the imponderable "Christmas factor") during therapy. And it takes only one technician to administer the thrombotest and record coagulation levels for 15 patients an hour at the outpatient clinic.

The method, which is recommended for dosage control of phenylindandione, dicumarol and similar oral anticoagulants, gives a combined determination of clotting factors II (prothrombin), VII (proconvertin), X (Stuart-Power) and IX (Christmas, PTC, antihemophilic globulin B).

The reagent contains crude cephalin prepared from human brain or soy bean, adjusted to give a 40 to 50 second "cephalin time" with human plasma; thromboplastin from animal organs, with a 35 to 40 second reaction time; calcium chloride, and adsorbed bovine plasma freed of the four factors but containing all other clotting factors in suitable concentrations.

Exactly 0.25 ml of this reconstituted reagent is pipetted into a test tube which is placed in the water bath for three to 30 minutes. The fingertip is swabbed and then jabbed deeply enough to give a free flow without "milking."

The first drops of blood are used: 0.05 ml is measured in a pipette as fast as possible, then blown into the test tube. At the same time, a stop watch is clicked on. Reagent and blood are mixed and the tube is left in the water bath for about 30 seconds.

DR. OWREN runs heart therapy clinic.

At short intervals thereafter, the tube is taken out of the water bath and tilted to spot the first sign of clotting. This is easy to see, since the whole mixture coagulates fairly suddenly. The time required for coagulation is recorded, the thrombotest percentage read from a calibration curve and a cross drawn on the patient's chart. It is as simple as that. And it takes no more than two or three minutes.

The Norwegian scientist separates candidates for long-term prophylaxis into two groups. First come those for whom anticoagulants have a "marked effect" on mortality and disablement. Next come those for whom the effect is less certain.

In the first group are patients with chronic rheumatic heart disease with embolism; angina pectoris for less than two years; myocardial infarction after the first attack; atherosclerosis in the legs (angina cruris); and intermittent cerebral circulatory insufficiency. Second priority cases include rheumatic heart disease without embolism; angina pectoris of more than two years' duration, and patients with two or more infarctions.

The effect of prophylaxis on the longevity of rheumatic heart patients who have had one or more embolisms is dramatic, according to Dr. Owren. However, this brings up an old question: Should treatment start before the first embolic episode, since the first episode is often catastrophic?

Risks Are Compounded

Age, fibrillation and a large left atrium compound the risk which, in Dr. Owren's opinion, is "often enough to justify therapy before the first episode."

Three studies have been conducted at the Oslo University clinic to measure the effect of long term therapy on angina pectoris. The first, in 1954, included 471 angina patients kept on anticoagulants an average of three years. Mortality per year was 3.6 per cent, against eight to ten per cent in 6,882 untreated American patients studied in 1952.

The second investigation, reported in 1957, revealed a five-year survival of 75 per cent in 275 angina patients on anticoagulants. Less than one per cent of those with a short history of symptoms prior to therapy died during the first year of therapy.

Last year, a more stringent double blind study of 203 patients was conducted at the Oslo clinic. One hundred were kept at a P-P (or thrombotest assay) level of 50 per cent and 103 at 20 per cent. Follow-up after one year disclosed that 13 of the first group had infarctions, compared with only two maintained at 20 per cent. Cardiac death rates in the two groups was eight to one. The optimum range for thrombotest-controlled anticoagulant treatment thus was confirmed at ten to 25 per cent of normal.

The results of therapy among the

CONTINUED ON PAGE 29

ANTICOAGULANTS CONTINUED

vast "myocardial infarction group"—with only one attack, no angina, or angina for less than two years—differ widely. The figures seem to suggest that the death rate in both treated and untreated cases was higher among patients with more than one previous infarction.

Dr. Owren also gives high priority for treatment to angina cruris sufferers with atherosclerosis in the legs, but without signs of coronary or cerebral atherosclerotic disease, because "they need protection against coronary death." Mortality is high among such patients, he pointed out. It was four per cent per year, among 120 on anticoagulants for an average of three years at the Oslo hospital, against eight to ten per cent in non-treated groups.

Anticoagulant Therapy Suggested

Intermittent insufficiency of the cerebral circulation, presumably because of thrombosis, also warrants treatment in Dr. Owren's opinion. The number of such patients is relatively small "but our experience has convinced us that they should have anticoagulant therapy.

What about the practitioner? Can he maintain his office patients on therapy and handle the monthly assays himself? He can, says Dr. Owren; his nurse can do the test. Of course he must know the simple rules of dosage and have a sharp eye for details. It takes about two months to master the art. If he is not interested in tackling the problem, he should be able to mail the citrated venous sample in a plastic tube in time to reach a control laboratory in two days. Some 50 practitioners in all of Norway's 20 counties cooperate in this manner with the University clinic.

Patients with severe hepatic or renal disease, active GI ulcer, hemorrhagic disease, malignant hypertension, mental aberrations or other specific contraindications, obviously are ruled out. "It is necessary to sit down with the patient and explain in detail what the purpose is, what the dangers are and that you expect him to follow directions absolutely. Never must he forget to take his pills, and never must he change the prescribed dosage."

Dr. Owren says his patients are pretty good about that. They understand that their lives may well depend on it. ■

SURGICAL 'CURES' CAN BE ALL IN THE MIND

A group of 'sham' operations prove that the power of the placebo extends to surgery

The placebo phenomenon is one of the most perplexing factors in the treatment of disease—especially when the treatment is surgical. In surgery, the effect is particularly hard to evaluate because it hinges not only on the "bias" of the patient, but also on that of the surgeon.

It has long been observed that placebo effects are most potent when there is strong motivation on the part of the patient towards recovery. Now, says Dr. Henry K. Beecher, chief of anesthesiology at Massachusetts General Hospital, studies have shown that the enthusiastic surgeon actually accomplishes more than one who is skeptical about a procedure, even

DR. BEECHER warns against MD "bias."

when they perform the same operation under similar conditions.

A case in point is internal mammary ligation. This operation, designed to relieve angina pectoris by increasing the blood flow to the heart, recently had a two-year popularity cycle in the U.S. Some benefit appeared to result and the surgery was enthusiastically received. Then a few sceptics began to report doubts about its actual effectiveness in angina. More and more skeptical surgeons began to report poorer results than the original enthusiasts.

Finally, it was put to an experimental test. A group of patients underwent an operation in which the mammary arteries were exposed and surgical sutures placed around them but not tied. Improvement in this group of "sham" operations was about the same as in a comparable series who had the full surgery.

Dr. Beecher, who 25 years ago founded the first laboratory devoted solely to research in anesthesia, warns: "It is essential that the surgeon be on his guard, lest he deceive himself and others in perpetrating costly, dangerous, even fatal operations whose effectiveness is only that of a placebo."

Pain, Stress and Relief

In addition to the surgeon's attitude, the source of pain may also obscure the placebo picture. There is evidence that placebos work better when the patient is under stress.

When pain is severe, he explains, placebos may account for as much as 77 per cent of the relief effected by drugs—as compared to a 35 per cent effect under ordinary conditions. Placebos are ten times more effective when anxiety accompanies the pain (as when it is of pathological origin) than if pain is accompanied by little stress (as when it is experimental).

Oddly enough, this holds true even for active drugs, Dr. Beecher notes.

"Some 15 groups of investigators have utterly failed to demonstrate any dependable effectiveness of morphine on experimentally contrived pain in man, whereas morphine is almost universally effective in alleviating pain of pathological origin."

He urges that more experimental studies be carried out to determine the actual effectiveness of new surgical procedures, because the placebo value of an operation does not justify the risk involved "when the price may be life itself."

As for other possible surgical candidates for the placebo label, Dr. Beecher comments: "I am not qualified to say that sympathectomy for hypertension is in that category. Nor am I saying that thymectomy for myasthenia gravis is placebo surgery. Others better qualified than I have raised the question." ■


to cope with the unpredictable

RELIEVES THE SYMPTOMS OF RHEUMATOID ARTHRITIS

the pain, rigidity, swelling, morning stiffness, and limitation of motion

With DECADRON, pain, rigidity, and swelling usually fade rapidly, within 24 hours.[1] Morning stiffness often disappears completely.[2] Increased joint mobility and eventual clinical control frequently follow improvement of articular symptoms, even in patients poorly controlled by other corticosteroids.[2-6]

ATTACKS THE INFLAMMATORY PROCESS OF RHEUMATOID ARTHRITIS

the rapid sedimentation rate, the secondary anemia, the fever, elevated plasma fibrinogen and globulin, and decreased plasma albumin

Treatment with DECADRON, by reducing or eliminating inflammation, may also be expected to help eliminate fever, reduce the sedimentation rate, correct abnormal plasma-protein patterns, raise hemoglobin values and red blood cell counts.[3,7-10]

IMPROVES THE GENERAL STATE AND SENSE OF HEALTH

The patient is sometimes markedly undernourished and emaciated

(Cecil, R. L., and Loeb, R. F.: A Textbook of Medicine, ed. 10, Philadelphia, W. B. Saunders Company, 1959, p. 1366.)

thin and asthenic, and very often profoundly depressed.

(Ragan, C., in Comroe's Arthritis and Allied Conditions, ed. 5, Philadelphia, Lea & Febiger, 1953, p. 151.)

The "tonic effect"[11] of dexamethasone often promotes a sense of well-being, leading to improvement in the general state of health, relief of asthenia and depression, restoration of normal nutrition and enjoyment of food.[1,3,11-14]

blpattern of rheumatoid arthritis

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Initial dosage depends on the type and severity of the condition. Generally between 1.5 mg. and 3 mg. per day is adequate; this should be reduced to maintenance level when control has been established. DECADRON is supplied as 0.75 mg. and 0.5 mg. scored, pentagon-shaped tablets and as Injection DECADRON Phosphate in 5-cc. vials, each cc. containing 4 mg. of dexamethasone 21-phosphate as the disodium salt. Additional information available to physicians on request.

Decadron®

DEXAMETHASONE

TREATS MORE PATIENTS MORE EFFECTIVELY

MSD MERCK SHARP & DOHME • Division of Merck & Co., INC., West Point, Pa.

CUBAN PHYSICIANS IN EXILE

CLASSES are given in English and Spanish at Univ. of Miami School of Medicine.

Refugees are willing to take any kind of job while trying to qualify for U.S. practice

From Havana to Miami is only 90 miles—a 40-minute flight. But for fleeing Cuban physicians, it's also the distance from successful private practices to unrewarding jobs as scrub nurses and hotel doormen.

Some 300, escaping Castro, have made the journey. Along with 4,500 other graduates of foreign medical schools, they will be taking the qualifying exam of the Educational Council for Foreign Medical Graduates on April 4. Failure, for most graduates, means a ticket back home. But for Cuban physicians-in-exile, there is no return ticket now.

Because of the Cubans' particular plight, two men in Miami have set up a unique medical education project, a tuition-free medical school in exile. They are Dr. Ralph Jones, Jr., chairman of the department of medicine of the University of Miami School of Medicine, and Dr. José Centurion, of the University of Havana.

"It was our idea," Dr. Jones explains, "to give these physicians the best educational experience possible in the shortest time. We wanted to give them the advantage of our knowledge so that when the opportunities are available, they can take the best advantage of their own knowledge."

The project got underway in early winter. For four evenings, Cuban physicians took comprehensive exams. The results helped Dr. Jones and his associate, Dr. Emil Taxay, to tailor courses the Cubans needed. Later, 244 men and 23 women (more than the whole physician population of Wyoming) entered the course.

Lectures in medicine are simultaneously translated—United Nations style—into Spanish.

University of Havana professors give brush-up courses for specialists who are rusty in fields other than their own. Everyone takes English.

DR. ANGLADA works days at a bakery.

Another Learning Process

Meanwhile, like thousands of other refugees from Castro's Cuba, they are going through another learning process: the adjustment from a secure life in their own homes to the unsettled life of people seeking sanctuary.

Many of them arrived in Miami after Castro had issued a $5 limit on the amount of money that could be taken out of the country. Most of the exiles had been middle class people with good incomes, homes, well-equipped offices, servants. Now their wives work in school lunchrooms and downtown offices, while their children attend day nurseries.

Emergency centers have been set up to register the exiles, give them inoculations, clothes, some money. Jobs have been found—although this has been increasingly difficult as Miami's Cuban population has doubled in less than a year. Like the others, the Cuban physicians are happy enough to get jobs in laundries or hotels. But unlike the others, the MDs are unequivocally closed off from their own profession.

Miami physicians, however, set up a special employment agency through a committee headed by Dr. Franklin Evans, past president of the Dade County Medical Association. Unable to find them positions as practitioners, the committee exerted efforts to obtain work for them as technicians or hospital employees, so they could "at least rub elbows with other doctors and see what is going on."

So far, the committee has found medical jobs for about 100 Cuban doctors. Some are helping with the special postgraduate course, some are working in local health departments, others are laboratory aides.

Mead Johnson & Company has contributed $10,000 in the form of scholarships. A large supply of badly-needed American medical textbooks, translated into Spanish, has been supplied by the W. B. Saunders Company. International Telephone and Telegraph Corporation has given $40,000. The American College of Surgeons and the American College of Chest Physicians sent money and offers of job help. In all, some $60,000 has been contributed.

Dr. Jones, the moving force behind the school in exile, is outspoken in his views about what should be done about Cubans—and other foreign graduates. On a recent NBC telecast, an interviewer provoked a typical reaction from Dr. Jones by asking how Cuban physicians might best be "used."

"They shouldn't be *used* at all," Dr. Jones retorted. "Our purpose is to prepare them so *they* can use their professional knowledge and skill to help solve some of this country's unmet medical needs, and if possible, to earn a living, or to pursue their careers in other countries. We also hope to enable them to do their jobs better when they are able to go home." ■

Scissors & Scalpel

ION LUNGS

It isn't just the smoke that's carcinogenic, it may also be the fire.

This latest brand plucked from the burning cigarette versus health controversy comes from Dr. Kenneth H. Kingdon, a research physicist at the General Electric laboratory.

Dr. Kingdon has found that the glowing tip of a cigarette generates a cloud of electrically charged particles—ions. He suggests that these particles when inhaled may be the biologically active materials that change normal lung tissue to cancerous cells.

This theory—which, he stresses, is yet unproved—is based on experiments which show that both positive and negative electrically charged particles in the atmosphere can have biological effects similar to those of x-irradiation. The possibility that these effects are associated with lung cancer, he writes in *Nature*, "appears to merit further exploration."

KUDOS AND KICKS

Underlying the difficulty of applying anticoagulants in therapy is a large, shadowy area in our basic knowledge of clotting mechanisms, says Dr. J. F. Mustard of the University of Toronto. "Find a new factor in physics and you get a Nobel Prize. Find a new factor in the clotting mechanism, and you get the kicks of your colleagues."

TOAD TARGET RANGE

Bufo terrestris is a fascinating specimen for the home terrarium and an interesting subject for the laboratory, but the toad refuses to eat unless the food is moving.

Keeping colonies of earthworms, meal worms or crickets is troublesome; hand-feeding by waving a pellet of hamburger on a toothpick in front of each individual is tedious.

To get around this difficulty two Connecticut researchers have devised a motorized Lazy Susan on which, they report, it is possible to feed a toad any food it finds palatable.

As described in *Science* by Walter and Francis Kaess, the food is placed on the rim of the slowly revolving disc. The toads approach the rim, flick their tongues and swallow. Five or six toads "knocking off pellets of hamburger like sharpshooters potting ducks in a shooting gallery (accuracy 95 per cent) make a spectacular sight."

FEAR ELIMINATOR

All of us at one time or another have stressed the prophylactic value of the periodical medical examination. Dr. George Day of Mundesley Hospital in Norfolk, England, wants to advertise its therapeutic benefit. Writing in the *British Medical Journal*, Dr. Day says: "Very few of us, even the healthiest in mind and body, emerge from a searching medical examination without a feeling of elation at being informed that all our accessible organs are still intact and functioning normally; for we so frequently harbor a fear—varying in intensity from a stifled nagging doubt to a positive phobia—that all is not well. Fear is humanity's commonest disease. Isn't it fun being able to cure or alleviate it so simply?"

Editor's Choice

PLACENTAL ABNORMALITIES A THREAT IN SECOND TRIMESTER

While complete circumvallate placenta in the second trimester occurs only about once in every 160 pregnancies, the defect is partially present much more often than recognized. In fact, its incidence is comparable to that of placenta previa, and is more frequent in multiparas. Vaginal bleeding is usually minimal, but hydrorrhea and intermittent uterine contractions may also be present in an appreciable number.

Moreover, nearly one-third of all cases of nontoxic separation of the placenta are associated with complete or partial circumvallate placenta due to degenerative changes in the decidua overlying the extrachorionic portion of the placenta. Because of this, there is a very high rate of placenta previa in such instances, and the fetus is placed in double jeopardy of premature birth or intrauterine death due to placental insufficiency.

Other conditions which also threaten the normal course of pregnancy during the second trimester are hydatidiform mole and choriocarcinoma. In the former condition, the uterine contents must be removed. In choriocarcinoma, prognosis has become more hopeful with the introduction of the antifolic compound, methotrexate. *Hall; Postgrad. Med., Feb. 1961, pp. 147-50.*

ANOTHER CARCINOGEN FOUND IN CIGARETTE SMOKE

Nickel carbonyl, a volatile gas formed during the burning of tobacco by the combination of nickel in the tobacco with carbon monoxide, is a potential carcinogen. When inhaled, nickel is presumably deposited on the respiratory mucosa in a highly active form.

Several popular brands of American cigarettes, cigars and pipe tobaccos contain significant amounts of nickel. In just one year, the two-pack-a-day smoker inhales three times the amount required to produce lung cancer in rats and 47 times the amount in a single carcinogenic dose. This is enough to warrent removal of this potential carcinogen from these products. *Sunderman and Sunderman; Am. J. Clin. Path., March 1961, pp. 203-09.*

INTESTINAL OBSTRUCTION CAUSED BY ENDOMETRIOSIS

In unexplained obstruction of the bowel, consider endometriosis as a possible diagnosis. Not infrequently, endometrial tissue invades pelvic organs, especially the rectosigmoid area where it may give rise to a concentric stenosing lesion. The diagnosis of this type of obstruction is seldom made preoperatively.

A case in point is a 45-year-old woman in whom the diagnosis of invasive and obstructive endometriosis of the sigmoid was clinched only after surgical and microscopic study. Preoperatively, the findings suggested a number of other possibilities ranging from amebiasis or acute pancreatitis to perforated diverticulum or ruptured ectopic pregnancy. *Webster; Am. Prac., March 1961, pp. 205-06.*

DOCTOR'S BUSINESS

Think it's impossible to get rich in this day of high taxes? Not so, says the Internal Revenue Service. IRS figures disclose that more sizeable fortunes have been made since World War II than in any comparable period. In 1959, for example, 257 Americans paid taxes on $1 million or more. Since the end of the war, the number of families earning $10,000 or over a year has tripled. And the proportion in the lowest income groups has been cut in half.

Double indemnity is giving way to triple indemnity in many life insurance contracts. The reason is buried in 1960 actuarial tables. They reveal that the rates charged for double indemnity (twice the face amount of the policy for accidental death) were too high. Many companies promptly offered triple indemnity at almost the same cost as double. Under the new provision, if death occurs in a common carrier — plane, bus, train, taxi — the insurance company will pay three times the face amount of the policy.

Physicians who personally prepare their own tax returns are finding many helpful hints in the Treasury Department's "Tax Guide for Small Business." For tax purposes, a profession is the same as a trade or business; equivalent standards apply. Local Internal Revenue offices have the 1961 edition, or it may be obtained (for 40c a copy) from the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

A nursing home may not be the advantageous investment it once was. In a letter to the "Chicago Sun-Times," Dr. Louis A. Terman maintains "the supply of beds now exceeds demand." And the Chicago physician says that as competition gets tougher, nursing homes will inevitably start cutting costs. When this happens, he says, "inferior patient care must result."

Physicians with retirement programs may soon get the same tax breaks given corporate employees. Rep. Eugene J. Keogh (D-N.Y.) claims the 1961 version of his bill contains none of the features that have proved legislative stumbling blocks in the past. Prospects for passage at this session of Congress, says Keogh, are better than ever.

Apparently some physicians still have a thing or two to learn about how to win Congressmen and influence legislation. During a speech in Austin, Tex., Rep. J. M. Kilgore (D-Tex.) said this: "I know of instances where well-intentioned doctors and groups of doctors have produced results opposite from those they sought." Kilgore's advice to MDs calling on legislators: "Instruct but don't advise, suggest but don't demand."

This is the time to buy one of those small foreign cars. Renault has cut its prices by $200. Suggested retail price for the Dauphine is now $1385 on the East Coast. Hillman has also sliced its price tag and now offers its 4-door sedan for $1599. Biggest foreign seller is still the $1565 Volkswagen, which shows no sign of reducing prices. American cars are also being sale-priced.

A leading industrial research group has added its voice to that of labor and Government in citing medical care as one of the leading causes of rising living costs. A study by the National Industrial Conference Board says that the cost of medical care (including drugs, hospitalization and doctors' fees) went up each and every month during the last five years. For comparative purposes, it points out that apparel rose for 33 months out of a 70-month period, food 35 months, transportation 42 months, housing 52 months and personal care 59 months. The study does not analyze what fraction of the medical care index is doctors' fees.

Building costs will dip this spring, a fact that should be noted by doctors with plans for building a new clinic, office or home. Construction has been sluggish and competition among builders is stiff. Building money will also be more easily available, with interest under six per cent in most areas.

Physicians with weight-watching patients can get a sneak preview of a new cook book designed to prevent overweight through better eating habits. Put out by Wesson Oil, it's said to avoid "fad diets" or tasteless substitutions. Physicians who write to Wesson, Box 777, Hinsdale, Ill., will get a free copy of the book, and forms enabling patients to do the same.

March

inner protection

Tain

(Triacetyloleandomycin, Triaminic® and Calurin®)

to contain upper respiratory infection

safe antibiosis

Triacetyloleandomycin, equivalent to oleandomycin 125 mg. This is the URI antibiotic, clinically effective against certain antibiotic-resistant organisms.

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Triaminic®, 25 mg., three active components stop running noses. Relief starts in minutes, lasts for hours.

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Calurin®, calcium acetylsalicylate carbamide equivalent to aspirin 300 mg. This is the freely-soluble calcium aspirin that minimizes local irritation, chemical erosion, gastric damage. High, fast blood levels.

TAIN brings quick, symptomatic relief of the common cold (malaise, headache, muscular cramps, aches and pains) especially when susceptible organisms are likely to cause secondary infection. Usual adult dose is 2 Inlay-Tabs, q.i.d. In bottles of 50. ℞ only. Remember, to contain the bacteria-prone cold...TAIN.

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Names in the News

POSTS AND AWARDS

Drs. Leo G. Rigler of Los Angeles, Calif., and **Vincent M. Archer** of Charlottesville, Va., received Gold Medals from the American College of Radiology at its 37th annual meeting in Chicago. Dr. Rigler is executive director of the combined Cedars of Lebanon and Mount Sinai Hospitals in Los Angeles, and Dr. Archer is professor of radiology and chairman of the department, University of Virginia School of Medicine.

Dr. Arthur J. Vorwald, professor and chairman of the department of industrial medicine and hygiene at Wayne State University College of Medicine received the highest honor awarded by the American Academy of Occupational Medicine.

Dr. David Lehr, chairman of the department of physiology and pharmacology of New York Medical College, designated by the University of Montreal to be its Claude Bernard visiting professor of the year.

Dr. Ray E. Trussell, director of the School of Public Health and Administrative Medicine, as well as associate dean for Public Health of the Faculty of Medicine at Columbia University, appointed New York City Commissioner of Hospitals, succeeding Dr. Morris A. Jacobs.

Dr. Robert Q. Marston, assistant dean of the Medical College of Virginia, named dean of the University of Mississippi Medical School and director of the University Medical Center.

Dr. Van Rensselaer Potter, professor of oncology and assistant director of the McArdle Laboratory for Cancer Research, University of Wisconsin, received the 11th Annual Bertner Foundation Award from the University of Texas M.D. Anderson Hospital and Tumor Institute.

Dr. William A. Jeffers, associate professor of medicine in the School of Medicine of the University of Pennsylvania, an authority on the surgical treatment of hypertension, is new scientific director and executive officer of the Life Insurance Medical Research Fund.

Gen. George Russell Callendar, M.D., director of Pathology and Allied Sciences, Veterans Administration, received a citation at the Annual Armed Forces Institute of Pathology Lectures for his outstanding contribution to pathology and medicine. Gen. Callendar first joined the Armed Forces Institute staff in 1912, when it was known as the Army Medical Museum, and was its director from 1920-1922 and from 1924-1929.

Dr. G. Adolph Ackerman, assistant professor of anatomy at the Ohio State College of Medicine, granted the 1961 Lederle Medical Faculty Award by the American Cyanamid Co., to encourage young physicians on medical school faculties to devote full time to teaching and research.

OBITUARIES

Dr. Heinz Lord, 43, secretary-general of the World Medical Association. A Peruvian citizen born in Germany of Swiss and German parents, he was imprisoned by the Gestapo during World War II for resistance-movement activities, but later resumed his medical career in Hamburg. He came to the U. S. in 1954 and was attending an AMA meeting at the time of his death; of a heart attack; Feb. 3, in Chicago.

Dr. Charles Camblos Norris, 86, professor emeritus of obstetrics and gynecology at the University of Pennsylvania Medical School; long interested in small game hunting and fishing, his collection of books on angling is considered one of the world's finest; Feb. 26, in Bryn Mawr, Pa.

Dr. Frederic Brush, 90, retired physician, hospital administrator and conservationist; a top-flight golfer, he studied the physiological effects of the game; he was a founder of the New York Heart Association and the Campfire Girls, an ardent hiker and author of many stories on outdoor life; Feb. 20, in White Plains, N. Y.

Dr. Edwin Pyle, 68, orthopedic surgeon and sailing enthusiast; after his retirement in 1953, he sailed around the world as a ship's doctor on a 96-foot brigantine; Feb. 25, in Washington, Conn.

Dr. Eustace H. Sloop, 83, a medical missionary who, with his wife, Dr. Mary Martin Sloop, founded a school and clinic for underprivileged mountain children in North Carolina 50 years ago; Feb. 6, in Crossnore, N. C.

ADVERTISER INDEX

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FDA: VICTIM OF A CAUTIOUS PSYCHOLOGY?

Morris Fishbein, M.D.

A Congressional hearing involving a respected Federal agency can have serious repercussions, as we reported in the last issue *(Drug Approval Lag Stirs Controversy,* MWN, Mar. 3). Intensified scrutiny of the Food and Drug Administration, spurred on by the Kefauver committee investigations, has apparently induced dilatory tactics which can certainly cause a loss to the pharmaceutical industry of millions of dollars. Further, for many persons a loss may ensue of millions of workdays — and even loss of life. The potential gains by comparison seem trivial.

A new remedy with astonishingly successful effect and infinitesimal side reactions in gynecological practice, for instance, is already widely in use in France, England and Canada but cannot be purchased in the U.S. I find that action is still pending on a new drug application made to the FDA more than five months ago. Another manufacturer tells me of three applications for drugs also used extensively in other countries but which cannot be processed for what seem, to the applicant, to be due to executive uncertainties in the FDA.

True, the FDA finds itself inadequately staffed for the great burdens thrown upon it. The number of new drug applications continues to grow rapidly. More than 700 food additives designed to enhance flavor, change color, smooth texture or prevent decay are being tested and offered for clearance. New household cleansers, new insecticides, new polishes, anything corrosive, irritating or potentially allergenic must obtain clearance.

Simple enforcement of the law is admittedly difficult. And when the enforcers are doubtful as to the meaning of words or the intent of the law, the problems multiply to the point of inhibiting action. If sulfonamides, insulin, penicillin, vitamin B_{12} or more recently killed vaccines against poliomyelitis had been held up, as new products are now being withheld from usage, the number of days of disability and of unnecessary deaths would have been incalculable. The remedies for tuberculosis such as streptomycin, PAS and isoniazid were released with far less delay than now prevails with remedies far less likely to cause possible damage through even unwise dosage. The history of chloramphenicol is like that of "off again, on again, gone again, Finnegan."

More Personnel, Less Harassment

We have probably the best food and drug legislation of any nation in the world. But failure to provide sufficient competent personnel to administer its provisions, or continuous harassment by exaggerted doubts aroused in legislative hearings, can inhibit and restrain FDA's usefulness.

FDA officials do not concede that they are victims of "cautious psychology." They feel rather that there is just too much to do because of increased work and new legislation. In any event, two independent investigations attest to the ethics and intent of the Food and Drug Administration. But the difficulties and the unnecessary delays are apparent, and something ought to be done about them.

Morris Fishbein

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